Tester, Test Q

Date of visit: 02/17/2015
DOB: 09/03/1977 Age: 37 yrs.
Medical record number: 100042
Account number: 100042

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CURRENT DIAGNOSES
1. Fever, unspecified
2. CAD of Native Coronary Artery
3. AICD in situ
4. Abnormal function study,Unspec
5. Atrial Flutter
6. Premature Beats, Unspecified
7. Dizziness
8. Atrial Fibrillation
9. Abnormal Wt gain

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ALLERGIES
Asparagus, Throat spasm
Ceclor, Hives and/or rash
Effexor, Intolerance-constipation

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MEDICATIONS
1. Baby Ayr Saline 0.65 % Drops, Take as Directed
2. clopidogrel 300 mg tablet, 1 by mouth daily
3. Lyrica 100 mg capsule, 1 by mouth daily

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HISTORY OF PRESENT ILLNESS

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REVIEW OF SYSTEMS
General/Constitutional: denies recent weight loss, denies recent weight gain, denies fever, denies chills, denies change in exercise tolerance
Integumentary: denies change in hair or nails, denies rashes, denies skin lesions
Eyes: denies diplopia, denies visual field defects, denies blurred vision, denies eye pain, denies discharge
Ears, Nose, Mouth, Throat: denies hearing loss, denies epistaxis, denies hoarseness, denies difficulty speaking
Respiratory: denies dyspnea, denies cough, denies wheezing, denies hemoptysis, denies orthopnea, denies PND
Cardiovascular: denies palpitations, denies chest pain, denies peripheral edema, denies syncope, denies claudication
Gastrointestinal: denies ulcer disease, denies hematochezia and denies melena
Musculoskeletal: denies venous insufficiency, denies arthritic symptoms, denies back problems
Neurological: denies strokes, denies TIA, denies seizure disorder
Psychiatric: denies depression, denies substance abuse, denies change in cognitive functions
Endocrine: denies heat/cold intolerance, denies polydipsia, denies polyuria
Hematological/Immunologic: denies food allergies, denies seasonal allergies, denies bleeding disorders

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PAST HISTORY

Past Medical Illnesses: no significant history of medical illness or disease; Cardiovascular Illnesses: no history of cardiovascular disease; Infectious Diseases: no significant history of infectious disease; Surgical Procedures: no significant surgical procedures performed; Trauma History: no history of significant physical trauma; NYHA Classification: I; Cardiology Procedures-Invasive: no invasive or interventional cardiovascular procedures performed; Cardiology Procedures-Noninvasive: no known non-invasive cardiovascular testing; Peripheral Vascular Procedures: no invasive peripheral vascular procedures performed; LVEF of 56% documented via cardiac cath on 01/05/2015

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CARDIAC RISK FACTOR SCREENING

Tobacco Abuse: Yes; Hyperlipidemia: No; Hypertension: Yes; Prior History of Heart Disease: No; Obesity: Yes; Sedentary Life Style: No; Age: Yes;

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SOCIAL HISTORY

Alcohol Use: denies any alcohol use; Smoking/Tobacco Use: denies any tobacco use;
Diet: regular diet without modifications; Exercise: no routine exercise program; Substance Abuse: denies the abuse of prescription or nonprescription drugs;

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FAMILY HISTORY

Brother -- Asthma

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PHYSICAL EXAMINATION

Vital Signs

Blood Pressure:
95/125 Sitting, Left arm, regular cuff

Pulse: 99/min.
Respirations: 33/min.
Weight: 204.00000 lbs.
Height: 77"
Temperature: 98.5
O2Sat: 98%
BMI: 24

Constitutional: cooperative, alert and oriented, well developed, well nourished, in no acute distress

Skin: warm and dry to touch, no apparent skin lesions, no apparent masses noted

Head: normocephalic, non tender, no palpable masses

Eyes: EOMS Intact, PERRL, conjunctivae and lids unremarkable

ENT: ears unremarkable, throat clear, without erythema, good dentition

Neck: no palpable masses or adenopathy, no thyromegaly, JVP normal, carotid pulses are full and equal bilaterally without bruits

Chest: normal symmetry, no tenderness to palpation, normal respiratory excursion, no intercostal retraction, no use of accessory muscles, normal diaphragmatic excursion, clear to auscultation

Cardiac: regular rhythm, S1 normal, S2 normal, no S3 or S4, apical impulse not displaced, no murmurs, no gallops, no rubs detected

Abdomen: abdomen soft, bowel sounds normoactive, no masses, non-tender, no bruits

Peripheral Pulses: femoral pulses are full and equal bilaterally with no bruits auscultated, popliteal pulses are full and equal bilaterally with no bruits auscultated, dorsalis pedis pulses are full and equal bilaterally with no bruits auscultated, posterior tibial pulses are full and equal bilaterally with no bruits auscultated

Extremities & Back: no deformities, no clubbing, no cyanosis, no erythema, no edema, there are no spinal abnormalities noted, normal muscle strength and tone

Psychiatric: appropriate mood, memory and judgment

Neurological: no gross motor or sensory deficits noted

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MEDICATION BEFORE VISIT

1. Baby Ayr Saline 0.65 % Drops Take as Directed

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MEDICATION TODAY

1. Baby Ayr Saline 0.65 % Drops Take as Directed
2. clopidogrel 300 mg tablet 1 by mouth daily
3. Lyrica 100 mg capsule 1 by mouth daily

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IMPRESSIONS/PLAN

This is the plan discussion for the patient on 2/17/2015.
Based on the symptoms and clinical findings Ms. Tester presents today, my initial impression is that he is experiencing either orthostatic episodes or vasovagal syncope. I will initially evaluate him with a resting EKG, echocardiogram and tilt table study. I have reviewed my recommendations with him as well as the risks and benefits of the ordered studies, and potential treatment and other diagnostic options that include medication, Holter monitoring and exercise stress testing if the tilt table study is negative.

I have requested that he refrain from driving or strenuous physical activity until his diagnostic evaluation is completed. Once the test results are available they will be forwarded to you for your review. I have scheduled him to return to see us as outlined. Please do not hesitate to contact me if you have any questions or require any further assistance.

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TODAYS ORDERS

1. Glucose --- 12: 1 week
2. Wellnes Panel: 2 weeks

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Cardiology Clinic Physician: Patrick Deal

Referring Physician: BRYCE, ROGER